Confidential Patient Health Record

Date:	I.D. #:

GO HEALTH CHIROPRACTIC

PERSONAL HISTORY

Referred to this Office by:_____

Name_____ Address_____

City_____ State_____ Zip Code_____

Home Phone_____ Birth Date_____ Age:_____ Sex: ☐ M ☐ F

Cell Phone_____ Height _____ Weight _____

E-mail Address_____ Social Security #_____

Driver's License Number_____ Business Employer_____

Type of Work_____ Business Phone_____

Circle one: Married Single Widowed Divorced Separated Name of Spouse_____

Spouse's Social Security #_____

Spouse's Employer_____ Type of Work_____

Business Phone_____ Name and Ages of Children_____

Name and Number of Emergency Contact_____ Relationship_____

Who is Responsible for the Bill, You and ☐ Spouse ☐ Worker's Comp ☐ Auto Insurance ☐ Medicare ☐ Medicaid

☐ Personal Health Insurance (Name)_____ ☐ Health Card #_____

Insured Person's Name _____ Date of Birth_____

CURRENT HEALTH CONDITION

Unwanted Health Condition(s): 1st _____ _____

2nd _____ _____

3rd _____ _____

4th _____ _____

Tell us how we can help: _____

_____

_____

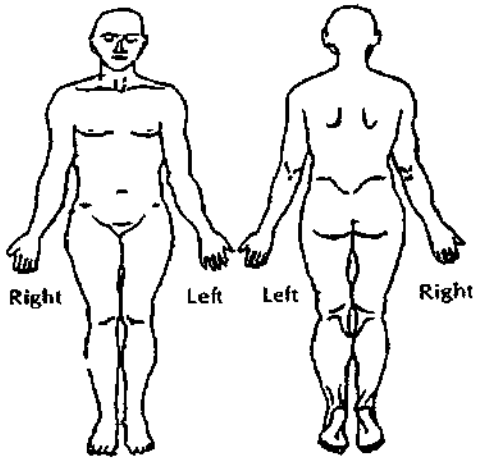
_____

_____

_____

_____

_____



Please outline on the diagram the area of your discomfort.

How would you describe the quality of pain (if applicable) in your worst area?

- ☐ Sharp
- ☐ Dull
- ☐ Diffuse
- ☐ Achy
- ☐ Burning
- ☐ Shooting
- ☐ Numb
- ☐ Tingly
- ☐ Sharp with motion
- ☐ Shooting with motion
- ☐ Stabbing with motion
- ☐ Electric like with motion

 4101-D W. Broadway Robbinsdale, MN 55422 Tel: 763-533-9997 Fax: 763-533-6058 www.gohealthchiro.com

Other doctors seen for this condition: ☐ Yes ☐ No_____ Who?_____

Type of Treatment_____ Results_____

When Did The Condition Begin?_____ Has This Condition Occurred Before? ☐ Yes ☐ No

Is Condition: ☐ Work Related ☐ Auto Accident ☐ Home Injury ☐ Fall ☐ Other_____

Date of Accident_____ Time of Accident_____

Have You Made a Report of Your Accident to Your Employer/Supervisor?: ☐ Yes ☐ No

List all prescription/Over the counter Medications/Supplements you are taking: _____

_____

Do You Wear A Shoe Inserts/Orthotics? ☐ Yes ☐ No

PAST HEALTH HISTORY

Major Surgery/Operations: ☐ Appendectomy ☐ Tonsillectomy ☐ Gall Bladder ☐ Hernia ☐ Back Surgery

☐ Broken Bones ☐ Other_____

Major Accident, Prior Auto Accident, Work Accident or Falls (Include Date): _____

_____

Hospitalization (Other than Above)_____

_____

Previous Chiropractic Care: ☐ None ☐ Doctor's Name & Approximate Date of Last Visit_____

Below are a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

☐ Pneumonia
☐ Rheumatic Fever
☐ Polio
☐ Whooping Cough
☐ Anemia
☐ Measles
☐ Mumps
☐ Small Pox
☐ Chicken Pox
☐ Cancer
☐ Heart Disease
☐ Thyroid
☐ Influenza
☐ Pleurisy
☐ Epilepsy
☐ Mental Disorders
☐ Lumbago
☐ Eczema

INTAKE
☐ Coffee
☐ Alcohol
☐ Cigarettes
☐ White Sugar

Have you been tested HIV positive? ☐ Yes ☐ No

CHECK ANY OF THE FOLLOWING YOU HAVE HAD THE PAST 6 MONTHS:

MUSCULO-SKELETAL CODE
☐ Low Back Pain
☐ Pain Between Shoulders
☐ Neck Pain
☐ Arm Pain
☐ Joint Pain/Stiffness
☐ Walking Problems
☐ Difficult Chewing/Clicking Jaw
☐ General Stiffness

☐ Gas/Bloating After Meals
☐ Heartburn
☐ Black/Bloody Stool
☐ Colitis

GENITO-URINARY CODE
☐ Bladder Trouble
☐ Painful/Excessive Urination
☐ Discolored Urine

FEMALES ONLY:
When was your last period?
_____

Are you pregnant?
☐ Yes ☐ No ☐ Not Sure

NERVOUS SYSTEM CODE
- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling Extremities
- ☐ Stress

C-V-R CODE
- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

GENERAL CODE
- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches

EENT CODE
- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

GASTRO-INTESTIONAL CODE
- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps

MALE/FEMALE CODE
- ☐ Menstrual Irregularity
- ☐ Menstrual Cramps
- ☐ Vaginal Pain/Infection
- ☐ Breast Pain/Infection
- ☐ Prostate/Sexual Dysfunction
- ☐ Other Problems
- ☐ _____
- ☐ _____
- ☐ _____

FAMILY HISTORY

I have an immediate family member that has:

- ☐ Rheumatoid Arthritis
- ☐ Diabetes
- ☐ Lupus
- ☐ Heart Problems
- ☐ Cancer
- ☐ ALS
- ☐ _____

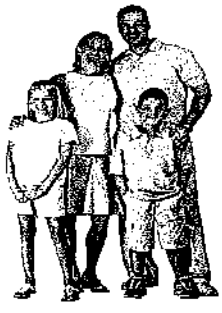
Most patients that come to our office have one of two objectives in mind concerning their health care. Some patients come for symptomatic relief of pain or discomfort (relief care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (corrective care). Your Doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

☐ Relief Care ☐ Corrective Care ☐ Check here if you want our doctors to select the type of care appropriate for your condition.

Relief Care

Relief Care is that care necessary to get rid of your symptoms of pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.



Corrective Care

Corrective Care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in length of time, but is more lasting.

Here are our office hours, please circle the day of the week along with the morning or afternoon that you are available.

Monday	8:30am-12:15pm &	2:30-5:45pm
Tuesday	N/A	2:30-5:45pm
Wednesday	8:30am-12:15pm &	2:30-5:45pm
Thursday	8:30am-12:15pm &	2:30-5:45pm
Friday	8:30am-12:15pm	N/A

****

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

If I am being seen for injuries as a result of a motor vehicle accident or work related injury and have hired a legal representative, I authorize and request my attorney to pay Go Health Chiropractic directly for my medical expenses from my pending claim for damages related to the accident I am being seen for. Furthermore, if no recovery is made on my behalf, I accept full responsibility for all charges.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

*Patient's Signature:*_____ *Date:*_____

*Guardian's Signature Authorizing Care:*_____ *Date:*_____

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the Chiropractic Physician, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, x-rays, diagnosis, and analysis. The chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or health care if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through health care procedures whatever he is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the Chiropractic Physician. The Chiropractic Physician provides a specialized, non-duplicating health care service. Your Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen.

I understand that if I am accepted as a patient by a physician at Go Health Chiropractic, I am authorizing them to proceed with any treatment and testing that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Patient Signature: _____ Date: _____

EHR Certification – Patient Information 2

Dear Patient: The US government is now requiring that we supply them with the following information:

PATIENT DEMOGRAPHICS:

Staff: (To be entered in EZnotes through "Edit Patient Info")

Name: (Print clearly) _____ Today's Date: _____

Date of Birth: _____

Ethnicity: (Please circle)

Hispanic or Latino	Not Hispanic or Latino

Race: (Please circle all that apply)

White	American Indian/ Alaskan Native	Asian
Black/African American	Native Hawaiian/ Pacific Islander	

Preferred Language: (Please circle)

English	Spanish	French	German	Italian
Mandarin	Cantonese	Tagalog	Japanese	Other_____

If there is an emergency, in which language would you like to receive the message?

_____

What is your preferred method of contact?

Phone Number: _____

Home	Work	Cell

Phone Call: ☐ Text: ☐ E-Mail: ☐

If email was not your preferred method, please give your email address here:

_____

Mailing Address: _____

_____

_____

For confidential correspondence, please create a Secret Question, i.e., What was my first pet's name?

Secret Question: _____

Secret Answer: _____

OFFICE USE ONLY

Vitals: In EZnotes, complete by 1) Going to "Exam" screen
2) "Select by region"
3) Then select "Vitals"

Blood Pressure: _____/_____ Height: _____ Weight: _____

Smoking Status:

Smokes every day	Smokes some days	Former Smoker	Never Smoked

If you smoke, how many cigarettes do you smoke per day?_____

PRESCRIBED MEDICINES

Check here if not taking any medications: ☐

Medication: i.e. Lipitor	# of MD refills issued:	Quantity of Pills:	Strength: i.e. 10 mg	MD's instruction: i.e. 1 per day

Are you allergic to any medicines? Please list each drug on a new line: Check here if you do not have any medical allergies: ☐

Name of Drug: i.e. penicillin	Symptom: i.e. headache	Severity: i.e. Mild, Moderate, Severe, Fatal

Have you been diagnosed with either of the following: (Please circle:)

Asthma?	Diabetes?	Hypertension (high blood pressure)?

I would like to electronically have access to my health information: (Please initial box) ☐

OFFICE USE ONLY

imely access: In EZnotes, complete by 1) Going to "Edit Patient" section for this patient ☐
3) Select "Asked *Timely Access*"
Completed?

Medications In EZnotes complete by
1) Going to "Edit Patient"
2) "Edit /View Patient's Data"
3) "Prescriptions/Allergies"

:ntered into EZnotes by (name): Date & Time: ☐
Completed?

INSURANCE FORMS/PAYMENT

If you receive any correspondence from your insurance carrier pertaining to the care you have received at this office or a request of more information regarding your care, please bring it in as soon as possible. It is very important that we keep your file as up to date as possible. **Occasionally, either by mistake, or due to provisions in your policy, the check issued by the insurance company for payment of services rendered in our office, may come to you instead of our office. If you should receive any unexpected check in the mail, be aware this is, more than likely, payment due at our office for services provided to you. I understand that I must bring in the checks immediately to this office and sign them over to Go Health Chiropractic. Failure to do so will result in collection efforts.**

I have read and understand the payment policy of Go Health Chiropractic. I understand that my insurance is an arrangement between myself and my insurance company, NOT between Go Health Chiropractic and my insurance company. I also understand that if my insurance does not respond within 60 days, or if I suspend or terminate my schedule of care as prescribed by the doctors at Go Health Chiropractic that fees will be due and payable immediately.

_____ _____

Patient's signature (or guardian if patient is a minor) Date

_____

Witness

GO HEALTH CHIROPRACTIC

the future of wellness

FINANCIAL POLICY

Our recommendations are based on a desire to see you get well and stay well. Although most of our patients choose to pay out of pocket for their care, Chiropractic care is covered under many insurance plans. Most of our patients that have health or accident insurance will fall under one of the plans discussed in this policy. Regardless of your coverage, please understand our doctors will make treatment recommendations based on your current state of health. We ask that you read and understand our policy as it applies to your particular situation.

BBB MEMBER

PATIENTS WITHOUT INSURANCE

We request that 100% of the first visit be paid at the time of the visit. On other visits, payment may be made per payment arrangement. We are happy to accept your cash, check, Master Card, American Express or Visa. If you have chosen this option, your signed financial arrangement will be in your file at our office and you will be provided a copy at your request.

GROUP OR INDIVIDUAL INSURANCE

Your insurance is an agreement between you and your insurance company, not between your insurance company and our office. We cannot be certain if your insurance covers Chiropractic, although most policies do provide coverage. The amount they pay varies from one policy to another. When possible, we will call to verify benefits on your insurance; however, the benefits quoted to us by your insurance company are not a guarantee of payment. As a courtesy to you, our office will complete any necessary insurance forms at no additional charge, and file them with your insurance company to help you collect. It is to be understood and agreed that any services rendered are charged to you directly and you are personally responsible for payment of any non-covered services, deductibles or co-pays. If you choose, you may pay the full amount due each day thereby qualifying for our Time of Service Reduction in fees. You may then submit the bill to your insurance carrier for reimbursement.

"ON THE JOB" INJURY (Worker's Compensation)

If you are injured on the job, your care should be paid for under your employer's Worker's Compensation insurance. You will need to inform your employer of the accident and obtain the name and address of the carrier of their insurance. If your employer does not provide us with this information, if a settlement has not been made within 3 months, or if you suspend or terminate care, any fees and services are due immediately.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS

Please present your auto insurance card, your health insurance card, and tell us if you have retained an attorney. There are four options available to the PI patient:

1. Pay cash for your care and we will submit reports whenever necessary.
2. We will bill (accept assignment) from the Med Pay portion of your auto insurance.
3. We will accept a Letter of Protection or Doctor's Lien from an attorney and await payment at the time of settlement as long as you remain an active patient.
4. We will bill your standard health insurance plan and you will be responsible for all co-pays and deductibles as they are incurred.

Although you are ultimately responsible for your bill, we will wait for settlement of your claim for up to three months after your care is completed. Once the claim is settled or if you suspend or terminate care, any fees for services are due immediately.

MEDICARE

We do accept assignment from Medicare. The check is usually sent directly to our office in payment of the services that Medicare will cover which for Chiropractors is ONLY manual manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible. All other services we provide are NON-COVERED. These services include, but are not limited to, x-rays, examinations, therapies, orthotics, supports, and/or nutritional supplements. Medicare patients are fully responsible for charges of non-covered services. Secondary insurance may or may not pay for these non-covered services. Our office completes and files the forms for Medicare at no charge. Maintenance care is not a covered service.

SECONDARY INSURANCE

Please inform us of any secondary insurance you may have. We will assist you if you need help in filing.

MANAGED CARE PLANS

We are preferred providers for the following companies: **BCBS, Medical Assistance** and **Medicare.** We are happy to be a non-participating provider for: **Health Partners, Medica, PreferredOne, Aetna and many others**. Please give our front desk staff you insurance cards. If you have chosen to utilize your healthcare benefits, your signed financial arrangement will be in your file at our office and you will be provided a copy at your request.

FLEX PLANS/MEDICAL SAVINGS ACCOUNTS

Please inform us if you have a medical savings account, sometimes known as a 'flex plan'. We will be happy to provide you with a statement of your charges for reimbursement.

CREDITS/PRE-PAYMENTS

If you account ever has a positive balance, due to a pre-payment, credit, or for any other reason, those funds will absolutely and completely expire and revert to a zero balance exactly one year from the last date/time you have actively treated at our office.